Payer Provider Workgroup

Meeting Agenda

Tuesday, August 13, 2019 1:30PM – 3:30PM (MT)

PTC Building (Health and Welfare Central Office)
450 West State Street – 10th Floor
Conference Room 10A
Boise, ID 83720

Registration URL: https://zoom.us/j/245046285
Dial in: +1 669 900 6833 Meeting ID: 245-046-285
One tap mobile +16699006833,,245046285#

Anti-Trust Statement: It is the policy of the Healthcare Transformation Council of Idaho (HTCI), to conduct all its activities, and the workgroups associated with HTCI's activities, in compliance with federal and state antitrust laws. During these meetings and other activities, including all informal or social discussions, each member shall refrain from discussing or exchanging competitively sensitive information with any other member.

1:30 p.m.	Welcome and opening remarks; roll call – *Norm Varin & Dr. Kelly McGrath* Co-Chairs
1:45 p.m.	Anti-Trust Statement – *Norm Varin & Dr. Kelly McGrath* Co-Chairs
1:50 p.m.	Member Introductions – *All*
2:05 p.m.	History and Background – *Cynthia York*
2:15 p.m.	Introduction of Draft Charter – *Casey Moyer, OHPI*
2:30 p.m.	Behavioral Health Integration Project – *Jen Y*
2:45 p.m.	Discussion of data sharing arrangements – *Norm Varin & Dr. Kelly McGrath* Co-Chairs
3:05 p.m.	Top 10 Spend Project – *Norm Varin & Dr. Kelly McGrath* Co-Chairs
3:20 p.m.	Meeting Schedule – *Norm Varin & Dr. Kelly McGrath* Co-Chairs
3:30 p.m.	Adjourn

CHARGE:

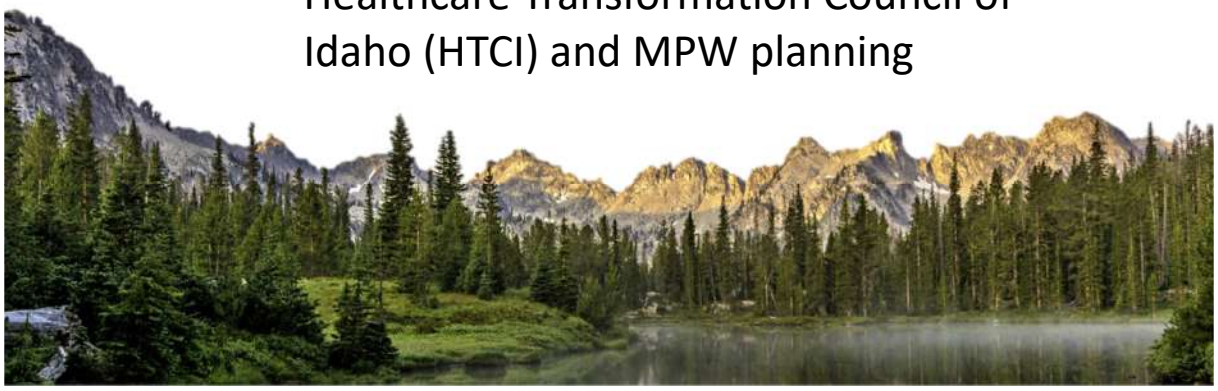
Promote the advancement of person-centered healthcare delivery system transformation efforts in Idaho to improve the health of Idahoans and align payment to achieve improved health, improved healthcare delivery, and lower costs.

FUNCTIONS:

- Promote and support transformation by identifying opportunities for innovation that will help shape the future of healthcare.
- Serve as a trusted source and a credible voice to strategically drive improvements in the healthcare delivery system.
- Serve as a convener of a broad-based set of stakeholders.
- Identify delivery system barriers that are preventing healthcare transformation and prioritize and recommend solutions.
- Promote alignment of the delivery system and payment models to drive sustainable healthcare transformation.
- Recommend and promote strategies to reduce overall health care costs.
- Utilize accurate and timely data to identify strategies and drive decision making for healthcare transformation.
- Promote improved population health through policies and best practices that improve access, quality, and the health of all Idahoans.
- Promote whole person integrated care, health equity, and recognize the impact of social determinants of health.
- Support the efforts in Idaho to provide a healthcare workforce that is sufficient in numbers and training to meet the demand.
- Promote efficiencies in the collection, measuring, and reporting of quality metrics.

Contents

- Multi-Payer Workgroup (MPW) History
- MPW Activities and Accomplishments
  - Data Collection
  - Quality Measure Set Alignment
- Healthcare Transformation Council of Idaho (HTCI) and MPW planning



Statewide Healthcare Innovation Plan

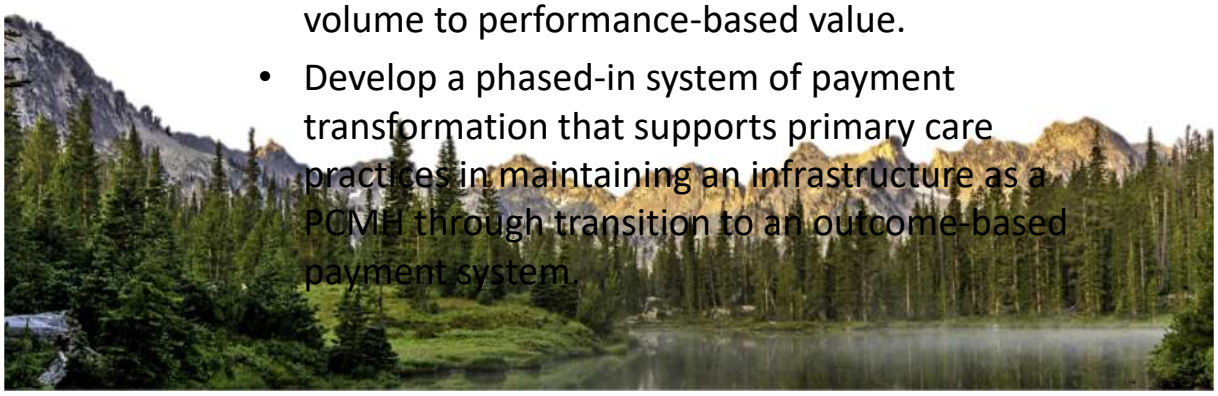
MPW History

Statewide Healthcare Innovation Plan

Original MPW Charge from the IHC

The MPW was formed to advise and address the funding reform needs of SHIP. The workgroup's charge is as follows:

- Through collaboration across payers and providers, transform payment methodology from volume to performance-based value.
- Develop a phased-in system of payment transformation that supports primary care practices in maintaining an infrastructure as a PCMH through transition to an outcome-based payment system.



Support for SHIP Goals

- Goal 6: Align payment mechanisms across payers to transform payment methodology from volume to value.
- Goal 7: Reduce overall healthcare costs.

MPW Membership

- Aetna
- Blue Cross of Idaho
- Department of Health and Welfare – Medicaid
- Essentia Health Clinics
- Futura Title and Escrow Corp (Self-Funded)
- Idaho Hospital Association
- Idaho Primary Care Association
- Molina Health Care of Idaho
- Mountain Health CO-OP
- Noridan Healthcare Solutions, LLC, Fargo
- PacificSource Health Plans
- Regence BlueShield of Idaho
- Select Health
- St. Alphonsus
- St. Luke's
- UnitedHealthcare

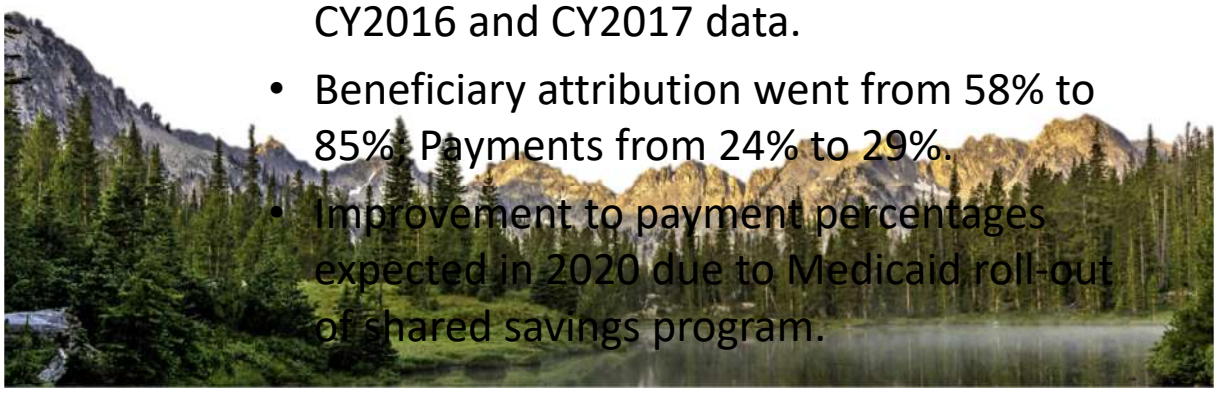
MPW Activities and Accomplishments

Data Collection

Data Collection

Goal 6 Payer Financial and Enrollment Metrics

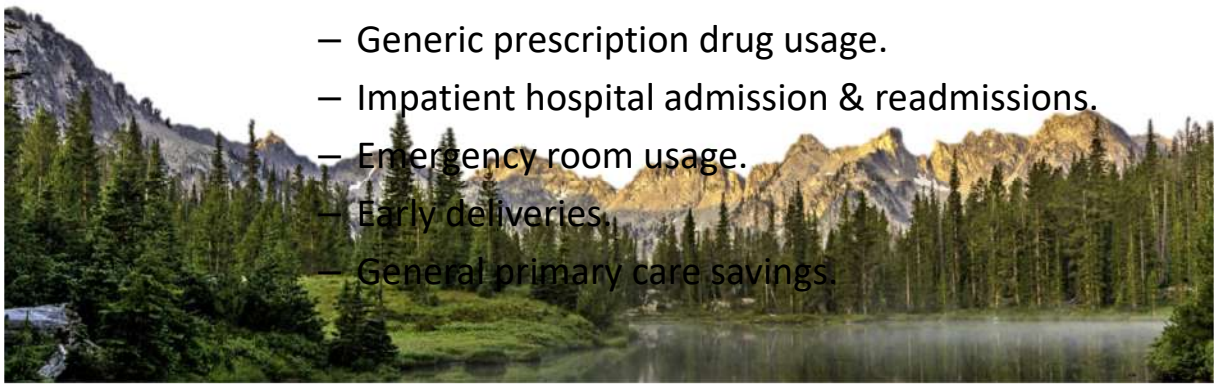
- Mercer collected data to compare enrollment and payment metrics from commercial payers, Medicare and Medicaid.
- Baseline CY2015 data was compared to CY2016 and CY2017 data.
- Beneficiary attribution went from 58% to 85%. Payments from 24% to 29%.
- Improvement to payment percentages expected in 2020 due to Medicaid roll-out of shared savings program.



Data Collection

Goal 7 Financial Analysis

- Mercer collected payer data to determine the impact of changes occurring through the SHIP on the State's healthcare costs.
- Targeted areas for expected cost avoidance:
  - Generic prescription drug usage.
  - Impatient hospital admission & readmissions.
  - Emergency room usage.
  - Early deliveries.
  - General primary care savings.



Data Collection

Goal 7 Financial Analysis

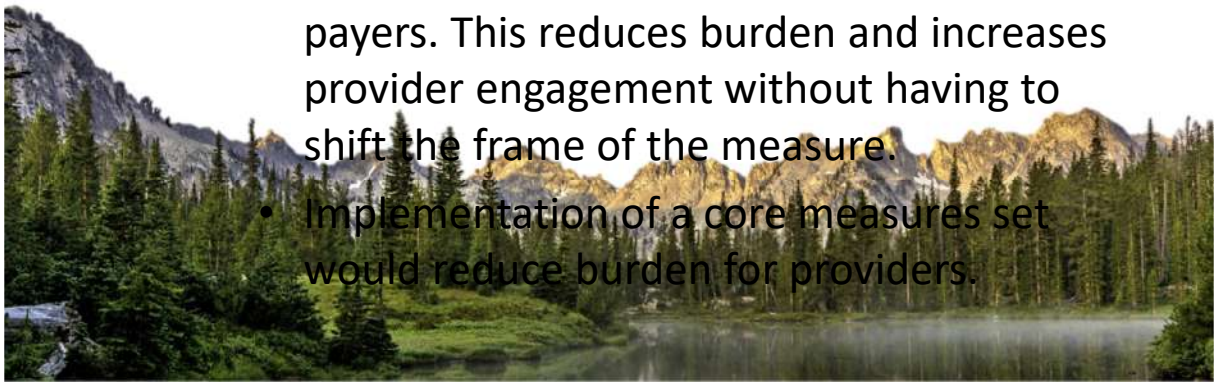
- Actual costs for the demonstration are projected to be over **$93.5 million lower** than if no intervention for SHIP or payment reform were taking place.
- SHIP financial goals continue to progress as expected after year two of the model test.
- Final report will be presented in December to MPW if data is submitted within the timeframe requested.

MPW Activities and Accomplishments

Quality Measures Alignment

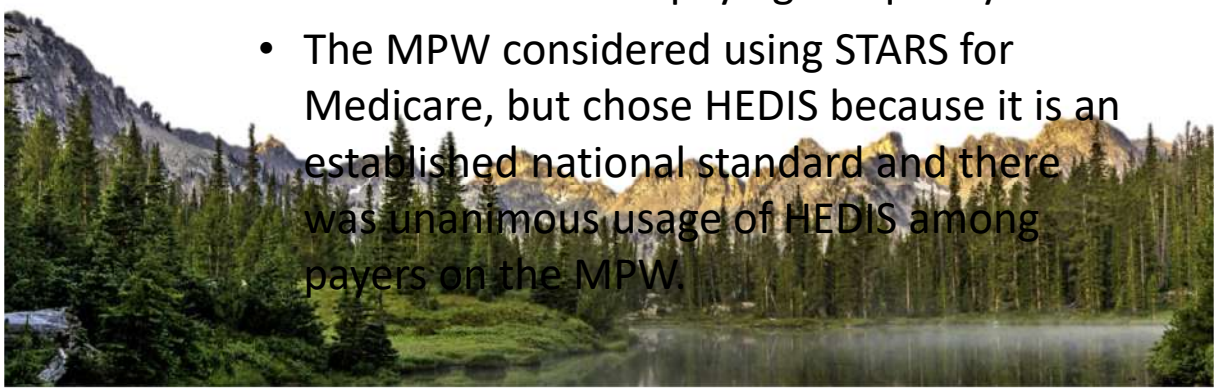
Background

- Providers are accountable for multiple similar but different quality measures.
- Providers have requested that, within a focus area (e.g., chronic disease), measured outcomes be consistent across payers. This reduces burden and increases provider engagement without having to shift the frame of the measure.
- Implementation of a core measures set would reduce burden for providers.



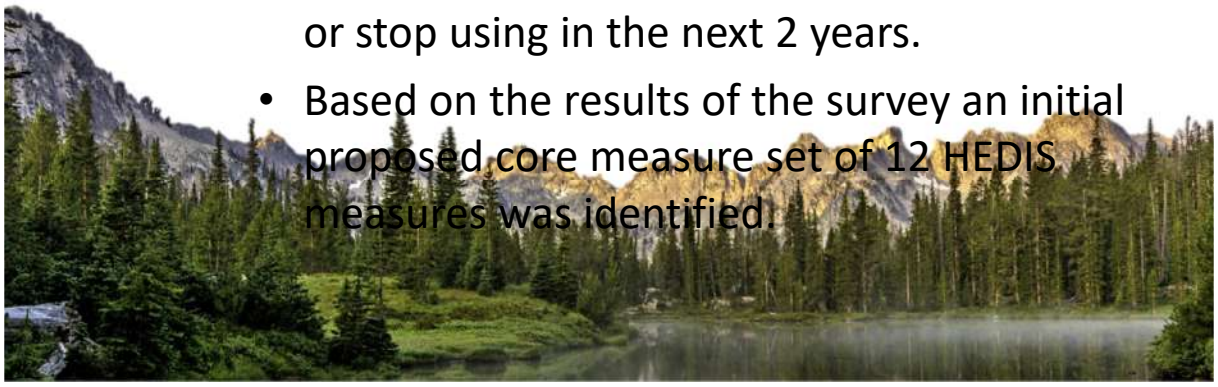
Quality Measures Survey

- The MPW developed a survey for payers to better understand which measures are currently used consistently across payers.
- Payers were surveyed on how they use HEDIS measures in paying for quality.
- The MPW considered using STARS for Medicare, but chose HEDIS because it is an established national standard and there was unanimous usage of HEDIS among payers on the MPW.



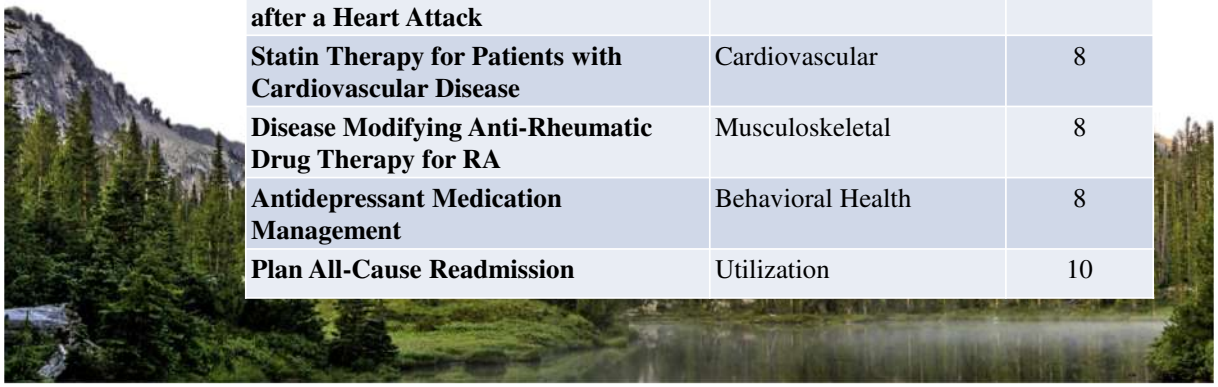
Quality Measures Survey

- Purpose of the survey was to identify the measures and disease categories where there was most alignment across payers.
- Payers were asked which measures they currently use, and which they plan to start or stop using in the next 2 years.
- Based on the results of the survey an initial proposed core measure set of 12 HEDIS measures was identified.



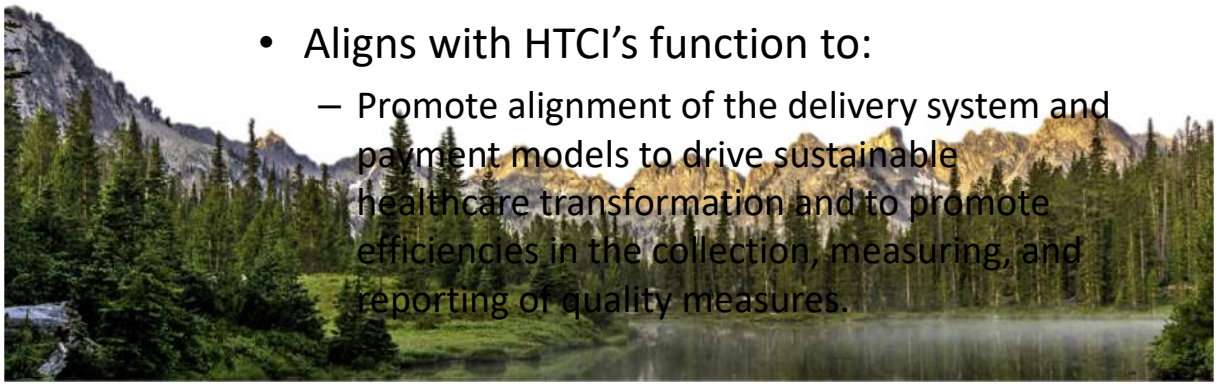
Survey Results – Top 12 Measures

Measure	Disease Category	Alignment Score[1]
Adult BMI	Prevention & Screening	10
Breast Cancer	Prevention & Screening	10
Colorectal Cancer Screening	Prevention & Screening	10
Medication Management Asthma	Respiratory	8
Controlling High Blood Pressure	Cardiovascular	10
Persistence of Beta-Blocker Treatment after a Heart Attack	Cardiovascular	8
Statin Therapy for Patients with Cardiovascular Disease	Cardiovascular	8
Disease Modifying Anti-Rheumatic Drug Therapy for RA	Musculoskeletal	8
Antidepressant Medication Management	Behavioral Health	8
Plan All-Cause Readmission	Utilization	10



Why this Work Should Continue

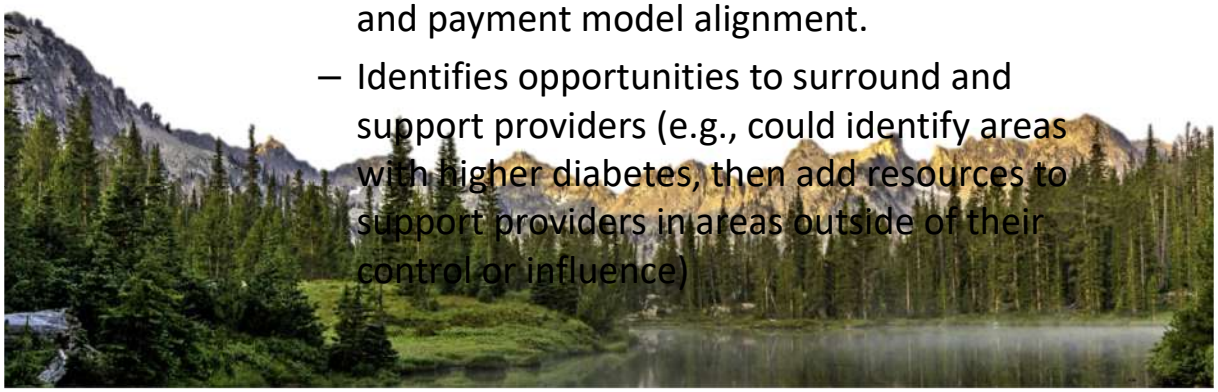
- The MPW supports alignment of an Idaho core quality measure set beginning in 2020.
- Payers and providers think alignment is valuable.
- Aligns with HTCI's function to:
  - Promote alignment of the delivery system and payment models to drive sustainable healthcare transformation and to promote efficiencies in the collection, measuring, and reporting of quality measures.



Statewide Healthcare Innovation Plan

Recommended Next Steps

- Designate a multi-payer/provider workgroup or entity that:
  - Continues to pursue measure alignment.
  - Provides expert information to the HTCI on barriers and opportunities for delivery system and payment model alignment.
  - Identifies opportunities to surround and support providers (e.g., could identify areas with higher diabetes, then add resources to support providers in areas outside of their control or influence)



MERCER
MAKE TOMORROW, TODAY

PAYER FINANCIAL AND ENROLLMENT METRICS FOR GOAL 6 THROUGH AWARD YEAR 3 (AY3)

September 6, 2018

INTRODUCTION

In calendar year (CY) 2017, Idaho's Statewide Healthcare Innovation Plan (SHIP) continued promoting the transformation of healthcare payments from volume-based payments to payments focused on outcomes coinciding with the implementation of the Patient-Centered Medical Home (PCMH) model of care. To support testing of Idaho's SHIP, Idaho received a four-year federal State Innovation Model (SIM) Test grant. As part of the grant's requirements, the State of Idaho (State) engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits, LLC to analyze financial metrics for the State population's health in an effort to measure the progress in moving from fee-for-service (FFS) to value-based payments.

STRATEGIES AND METHODS FOR VALUE-BASED PAYMENTS

The State's multi-payer approach shifting from FFS payments to value-based payment strategies is expected to achieve a long-term, sustainable impact on the State's healthcare system. In AY3, payers continued to move away from FFS and towards value-based payment through several methods, including:

- Pay-for-Performance (P4P)
- Enhanced P4P
- Shared Savings
- Shared Risk
- Full Risk
- Quality Bonuses
- Population-Based Payments
- Episode-Based Payments

In addition to the Patient-Centered Medical Home (PCMH) model of care, payers are testing alternative models including accountable care organizations (ACOs) with many of the State's acute care hospitals.

Payers also support total-cost-of-care programs with shared savings payments for improving and managing patients with chronic conditions to reduce avoidable emergency room visits.

The multi-payer approach includes:

- Understanding each payer's need to design and implement payment models that they believe fit their organization's goals and are most effective for their beneficiaries and provider partners.
- Recognizing that system wide transformation to value-based purchasing will only occur across Idaho payers if payers are participating as leaders of the change rather than responding to mandates.
- Acknowledging that payment transformation may not occur quickly in the State but, through partnership with payers, new reimbursement models will emerge that have a positive impact on the system statewide. Implementation of new reimbursement models representing at least 80% of the beneficiary population is the goal for the State and is underway.

To collect payer data for tracking the State's progress in shifting to value-based payments, an Idaho alternative payment model framework was developed by the Multi-Payer Workgroup. The model follows the Health Care Payment Learning and Action Network model and reflects the different payment methodologies in the Idaho marketplace.

BASELINE FOR IMPROVEMENT COMPARED TO AWARD YEAR 3

The overarching aim of the State's integrated multi-payer PCMH model is to improve quality outcomes and beneficiary experience, which is expected to lower the cost of healthcare. Transforming from a FFS reimbursement model to payment models that incentivize quality outcomes and improved beneficiary experience is a key goal to achieve this aim. Evidence of the transformation from paying for volume to paying for value will be shown by comparing the enrollment and payment metrics from commercial, Medicare and Medicaid payers throughout the State for each award year.

Data Requests

To measure progress, the baseline of CY 2015 data was compared to CY 2016 and CY 2017 data. Payers were asked for both years to provide percentages of beneficiaries and percentages of payments in the following categories:

- Category 1: FFS — no link to quality and value. Example is FFS payments.
- Category 2: FFS — link to quality and value. Examples include a) foundational payments for infrastructure and operations, b) pay for reporting, c) rewards for performance, and d) rewards and penalties for performance.
- Category 3: Value methodologies built on FFS architecture. Examples include a) methodologies with upside gainsharing and b) methodologies with upside gainsharing/downside risk.

SHIP IS SUPPORTED BY FUNDING OPPORTUNITY NUMBER CMS-1G1-14-001 FROM THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTERS FOR MEDICARE & MEDICAID SERVICES.

- Category 4: Population-based payment. Examples include a) condition-specific population-based payments and b) comprehensive population-based payments.

To assist in compilation, the data request also asked for total dollars paid for medical services in both years. The data request forms did not change from year to year.

Mercer's Client Confidentiality Agreement was signed by commercial payers and Mercer to ensure their data was protected and kept private. The agreement covers all four award years. It was agreed that the data would be aggregated across payers so no individual payer data would be discernable.

Data Compilation

Upon receiving data from five of the State's largest payers, including Medicare and Medicaid, Mercer collected comparison data from public documentation, including KFF.org and statutory filings in the National Association of Insurance Commissioners format. Data was weighted for both enrollment and payment information by payers to combine the data and protect the privacy of commercial respondents.

TABLE 1: PERCENTAGE OF BENEFICIARIES PER CATEGORY FOR CY 2015, CY 2016 AND CY 2017

	MEDICAID			COMMERCIAL & MEDICARE ADV.			MEDICARE			TOTAL		
CALENDAR YEAR	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017
Category 1: FFS without quality	100%	13%	13%	21%	22%	23%	8%	7%	6%	42%	15%	15%
Category 2: FFS with quality and value	0%	87%	87%	73%	71%	59%	72%	75%	78%	51%	77%	73%
Category 3: Methodologies built on FFS architecture	0%	0%	0%	4%	4%	13%	20%	18%	16%	6%	8%	11%
Category 4: Population-based payment	0%	0%	0%	2%	2%	4%	0%	0%	0%	1%	1%	2%

SHIP IS SUPPORTED BY FUNDING OPPORTUNITY NUMBER CMS-1G1-14-001 FROM THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTERS FOR MEDICARE & MEDICAID SERVICES.

TABLE 2: PERCENTAGE OF PAYMENTS (PAID OR ACCRUED) PER CATEGORY FOR CY 2015, CY 2016 AND CY 2017

	MEDICAID			COMMERCIAL & MEDICARE ADV.			MEDICARE			TOTAL		
CALENDAR YEAR	2015	2016	2017	2015	2016	2017	2015	2016	2017	2015	2016	2017
Category 1: FFS without quality	100%	99%	99%	71%	67%	61%	43%	45%	45%	76%	75%	71%
Category 2: FFS with quality and value	0%	1%	1%	19%	20%	18%	37%	37%	39%	16%	16%	17%
Category 3: Methodologies built on FFS architecture.	0%	0%	0%	7%	9%	12%	20%	18%	16%	7%	8%	8%
Category 4: Population-based payment.	0%	0%	0%	3%	4%	9%	0%	0%	0%	2%	2%	4%

Analysis

In CY 2017, all payer types remained consistent in their assignment of beneficiaries to value-based payment arrangements with incentives for providers based on quality and value. Gain-sharing, risk-sharing and population-based payments were completing their second year in the Medicare and commercial settings and additional assignments were relatively consistent for new membership. While membership attribution remains strong, payments were still primarily FFS. However, the CY 2017 data improved slightly with gains in categories 2, 3 and 4 compared to CY 2016 and CY 2015, driven by commercial and Medicare.

Anecdotal evidence suggests that payers and providers are limited in their ability to accept quality-based payments due to system limitation and increased risk due to the lack of beneficiaries assigned to each provider or were waiting to see the outcomes of initial assignments. Some payers required minimum levels of beneficiaries, such as 1,000 beneficiaries, before quality or risk-based payment arrangements replaced FFS.

SHIP IS SUPPORTED BY FUNDING OPPORTUNITY NUMBER CMS-1G1-14-001 FROM THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTERS FOR MEDICARE & MEDICAID SERVICES.

Medicaid continued the Health Connections PCMH program in CY 2017, although the design phase of the program was extended. The program includes four tiers with PMPM payments ranging from $2.50 to $10.00. While Medicaid members were attributed to primary care clinics, payments remained primarily FFS in CY 2017. At the request of providers, however, beginning July 1, 2019, Idaho Medicaid will expand Healthy Connections program to include shared savings for primary care practices and ACOs through direct contracts and through participation with regional care organizations. Medicaid is implementing several programs that cover a broad range of healthcare transformation activities and population-based care management initiatives. All Medicaid beneficiaries will be attributed to primary care, either through beneficiary choice or, if no choice is made, prior claims history or proximity to providers. In designing its payment program options, Idaho Medicaid is proposing a financial risk structure consistent with the Advanced APM standard of “more than nominal financial risk”, allowing participating clinicians to pursue the APM with Medicare, as allowed under the Medicare Access and Children’s Health Insurance Program Reauthorization Act of 2015. Medicaid expects to make the first shared savings payment in CY 2020.

SHIP IS SUPPORTED BY FUNDING OPPORTUNITY NUMBER CMS-1G1-14-001 FROM THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTERS FOR MEDICARE & MEDICAID SERVICES.

HEALTH WEALTH CAREER

IDAHO STATEWIDE HEALTHCARE INNOVATION PLAN

FINANCIAL ANALYSIS FOR AWARD YEAR 3

JULY 20, 2018

Idaho Healthcare Coalition

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EXECUTIVE SUMMARY

In 2017, Idaho's Statewide Healthcare Innovation Plan (SHIP) continued promoting the transformation of healthcare payments from volume-based payments to payments focused on outcomes coinciding with the implementation of the patient-centered medical home (PCMH) model of care. To support testing of Idaho's SHIP, Idaho received a four-year federal State Innovation Model (SIM) Model Test grant. As part of the grant's requirements, the State of Idaho (State) engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to analyze financial metrics for the State population's health in an effort to determine the impact of changes occurring through the SHIP on the State's healthcare costs. Targeted areas for expected cost avoidance through trend reductions from the implementation of the SHIP PCMH model were identified as generic prescription drug usage, inpatient hospital admission and readmissions, emergency room usage, early deliveries and general primary care savings.

It is important to note that, in addition to the SHIP, the State's payers and providers are implementing a number of other delivery and payment strategies with the goal of improving health outcomes and lowering costs. Thus, the dynamic environment in which the SHIP is being implemented limits the ability to determine the impact of the changes in healthcare costs that can be attributed solely to the SHIP. However, based on national research which shows decreased costs have resulted from the PCMH model, the SHIP is on pace to "bend the cost curve" and is believed to be a significant contributor to the impacts identified through this analysis.

The analysis showed that overall per member per month (PMPM) trend costs rose 3.4% from 2016 to 2017 and 9.5% from 2015 to 2017, which was on par with the projected per capita trend of 4.6% projected for 2016 to 2017 and 9.0% from 2015 to 2017, respectively, by the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary (OACT)[1]. However, when analyzing cost avoidance by payer, Medicare ($57.3 million) and Medicaid ($66.3 million) cost avoided exceeded increased costs incurred by commercial payers ($30.1 million) by $93.5 million. Furthermore, Medicare and Medicaid showed significant progress overall toward achieving their cost avoidance

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2017Tables.zip

targets for PCMH services. In 2017, Medicare showed decreases in PMPM costs in nearly all categories except other professional services.

The reported population includes three of the four largest commercial payers in Idaho, Idaho Medicare and Idaho Medicaid, representing roughly 1.1 million of Idaho's 1.6 million people. Actual costs for the demonstration are projected to be over $93.5 million lower than if no intervention for the SHIP or payment reform were taking place. The costs indicate the financial goals of the SHIP continue to progress as expected after year two of the model test.

2
INTRODUCTION

The objective of Idaho's SHIP is to improve the health of all Idahoans by shifting the healthcare delivery system to a patient-centered focus while lowering the overall cost of healthcare through the implementation of the PCMH model of care. One method to lower overall costs is by shifting healthcare payments from volume-based payments to payments focused on outcomes.

The Center for Medicare and Medicaid Innovation (CMMI) selected Idaho for a federal SIM Test grant to support testing of Idaho's SHIP. The four-year grant is comprised of an initial year of preparing to implement the model and referenced as Award Year (AY) 1. The following three years of the grant are to test the model's impact, including the financial impact on Idaho's healthcare system. The "Model Test Years" correspond to AYs 2 to 4. Idaho's selection of the PCMH model of care as a key tenant of its SHIP is supported by both national and state experience.

A decrease in cost was shown from the 2014 evaluation of Idaho's pilot PCMH model. Piloted through the Idaho Medical Home Collaborative in 2013 and serving approximately 9,000 patients, the evaluation found approximately $2.4 million in savings for Idaho's Medicaid program over each year of the project. The majority of primary care practices participating in Idaho's pilot were nationally certified PCMH practices.

However, payers are concurrently testing other initiatives along with the PCMH model. Other important delivery and payment approaches share the common goal of improved health outcomes and lower costs. The largest commercial payers in the State have all implemented alternatives to fee-for-service (FFS) payments to incentivize and reward quality and improved health outcomes. These payment models include:

- Pay-for-Performance (P4P)
- Enhanced P4P
- Shared Savings
- Shared Risk
- Full Risk
- Quality Bonuses
- Population-Based Payments

- Episode-Based Payments

In addition to the PCMH model, commercial payers are continuing to test alternative models including accountable care organizations (ACOs) with many of the State's hospitals, including total cost of care programs with shared savings payments for improving and managing patients with chronic conditions to reduce avoidable emergency room visits. Payers are also aligning their incentivized quality metrics to guide members to providers delivering high quality care. They are also working to expand value-based programs in an effort to align reimbursements, empower providers with data, focus on overall health and establish shared decision making between patients and their physicians. Together, payers and providers are developing the infrastructure to support partnerships to be successful in new payment arrangements and align payment systems with benefits, network design and consumer engagement.

Medicaid is expanding the payment reform model in Idaho by incentivizing participation in the PCMH model.[2] Medicaid also is encouraging value-based purchasing through the development of accountable Regional Coalition Organizations where physicians, providers and hospitals join together to create a regional system of care. Through both models, healthcare providers are rewarded for delivering better care instead of being paid for providing "more care" regardless of outcomes.

Idaho believes that the combined efforts of Idaho's commercial payers, Medicaid and the SHIP to implement delivery and payment models that incentivize and reward quality care will have a significant impact on improving the health of Idahoans. In addition, as demonstrated through this financial analysis, there is evidence that these combined efforts are bending the cost curve of the State's healthcare system.

[2] http://healthandwelfare.idaho.gov/Default.aspx?TabId=216

3
BACKGROUND

As part of the SIM grant, the Idaho Department of Health and Welfare (IDHW), together with the Idaho Healthcare Coalition, engaged Mercer to analyze financial metrics for the State's population health in an effort to determine the impact of healthcare cost changes occurring through the SHIP. This financial analysis also fulfills a grant requirement as the Center for Medicare and Medicaid Innovation (CMMI) seeks to understand the financial impact of healthcare delivery and payment models being tested across the nation.

Idaho's SHIP model testing is occurring within a dynamic health system environment. As such, this analysis is limited in that the impact of the SHIP PCMH model on utilization and costs cannot be isolated. Furthermore, while the population health metrics selected for this analysis are those that are most expected to be impacted by the PCMH model, it is expected that these metrics are also impacted by other payer models being implemented in Idaho. Regardless of these inherent limitations, national research supports the assumption that the PCMH model is a significant contributor to the findings of this financial analysis.

GRANT YEAR VERSUS CALENDAR YEAR

The grant period runs from February 1, 2015 through January 31, 2019, and is divided into award years as described previously and shown in Table 1 below. For ease of data collection and participation from the payers, Mercer is collecting and calculating data on a calendar year (CY) basis without adjusting for the lagging grant month. Therefore, although the Model Test years begin on February 1 and end on January 31, CY projections were not adjusted for the lagging month.

TABLE 1: REFERENCES TO TIME PERIODS

FINANCIAL ANALYSIS YEAR DATA/GRANT YEAR	GRANT AY	MODEL TEST YEAR
CY 2015 / February 1, 2015 through January 31, 2016	AY 1	Baseline (Year 0)
CY 2016 / February 1, 2016 through January 31, 2017	AY 2	Year 1
CY 2017 / February 1, 2017 through January 31, 2018	AY 3	Year 2
CY 2018 / February 1, 2018 through January 31, 2019	AY 4	End of Model Test (Year 3)

4

PROJECTED IMPACT OF IMPLEMENTING THE SHIP

In 2015, Mercer projected cost mitigation through trend reductions from the implementation of the PCMH model over the Model Test period. The areas expected to be impacted by the PCMH model were generic prescription drug usage, inpatient hospital admission and readmissions, emergency room usage, early deliveries and general primary care savings. The cost savings assumptions were based on research from similar PCMH impact studies. Cost increases associated with new PCMH operations being implemented were also built into the model.

Table 2 below identifies the cost mitigation assumptions.

TABLE 2: COST TARGETS, MILESTONES AND SAVINGS FOR PUBLIC/PRIVATE POPULATIONS COMBINED

COST AVOIDANCE CATEGORY	END OF MODEL TEST TARGETS	MECHANISM	SAVINGS ASSUMPTIONS
Early Deliveries (in weeks 37–39 of gestation)	5.0% reduction in expenses related to elective and non-elective preterm birth, prior to 39 weeks	1.0%–4.0% of total Neonatal Intensive Care Unit (NICU) admissions ($40 thousand–$70 thousand/admit) are preventable with later deliveries	0.56% reduction in Inpatient Hospital utilization for Medicaid child per year[3]
Generic Drug Use	Generic fill rate of 85.0%	Each 1.0% improvement in generic fill rates reduces total pharmacy spend (0.5%–1.0% Medicaid, 0.5%–1.0% commercial)	0.17% reduction in prescription unit costs for Medicaid and commercial per year over 3 years[4]

[3] Ohio Perinatal Quality Collaborative 39-Weeks Delivery Charter Project (2008) https://opqc.net/node/157

[4] Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results, 2012. Nielsen, Langner, Zema et al. Patient-Centered Primary Care Collaborative viewable at http://www.pcpcc.org/sites/default/files/media/benefits_of_implementing_the_primary_care_pcmh.pdf

COST AVOIDANCE CATEGORY	END OF MODEL TEST TARGETS	MECHANISM	SAVINGS ASSUMPTIONS
Hospital Readmissions	5.0%–10.0% reduction	20.0% of all hospitalizations are preventable re-hospitalizations	0.5% reduction in Inpatient Hospital utilization for Medicare and Medicaid, 0.33% reduction for commercial[5]
Acute Care Hospitalizations	1.0%–5.0% reduction	PCMHs reduce with IMPACT[6] & Intensive Outpatient Care Programs training	0.5% reduction in Inpatient and Outpatient Hospital unit cost for Medicare and Medicaid, 0.25% reduction for commercial[7]
Non-Emergent Emergency Department (ED) Use	5.0%–10.0% reduction in total ED use	10.0%–30.0% of ED visits are non-emergent	1.0% reduction in ED utilization for all payers[8]
General Primary Care Savings	Reduction in utilization	Savings typical when moving to a care management setting	0.5% reduction for Medicare and Medicaid for Specialists, Physical therapy, Occupational therapy and Radiology; 0.25% in DME for Medicaid Duals, 0.25% for Medicare Duals[9]

[5] Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results, 2012. Nielsen, Langner, Zema et al. Patient-Centered Primary Care Collaborative viewable at http://www.pcpcc.org/sites/default/files/media/benefits_of_implementing_the_primary_care_pcmh.pdf

[6] IMPACT is an evidence-based depression care program developed by the University of Washington. Most IMPACT materials, training, consultation and other assistance to adapt and implement IMPACT are offered free thanks to the generous support of the John A. Hartford Foundation.

[7] Health Affairs, Health Policy Brief on Patient Engagement. February 14, 2013 viewable at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=86

[8] Effect of a Multipayer Patient-Centered Medical Home on Health Care Utilization and Quality: The Rhode Island Chronic Care Sustainability Initiative Pilot Program. JAMA Internal Medicine, Report Abstract published online, September 9, 2013 viewable at http://archinte.jamanetwork.com/article.aspx?articleid=1735895

[9] Health Affairs, Health Policy Brief on Patient Engagement. February 14, 2013 viewable at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=86

As part of the model testing grant application, Mercer built a comparison model of care using medical expense data supplied by 1) the IDHW for 2013 and 2014 incurred expenses, 2) the OACT for 2012 and 2013 incurred expenses, 3) three of the four largest commercial payers for 2014 and 4) Mercer's proprietary commercial claims database. Mercer also used commercial payers' public filings, as available from 2013 and 2014. Membership was assumed to remain constant and no shift between payers was included in the model. Costs were trended forward using trend rates based on the U.S. Consumer Price Index (CPI) for medical care services to align reporting periods, yielding a baseline for comparison of CY 2015 as the Baseline. Trend assumptions for each Model Test year for Medicare and Medicaid were derived from the National Health Expenditure projections from the CMS OACT. Trend assumptions for commercial data for the same periods were derived from Mercer's proprietary commercial claims database. The results showed a projected cost avoidance of $89 million over the model testing period.

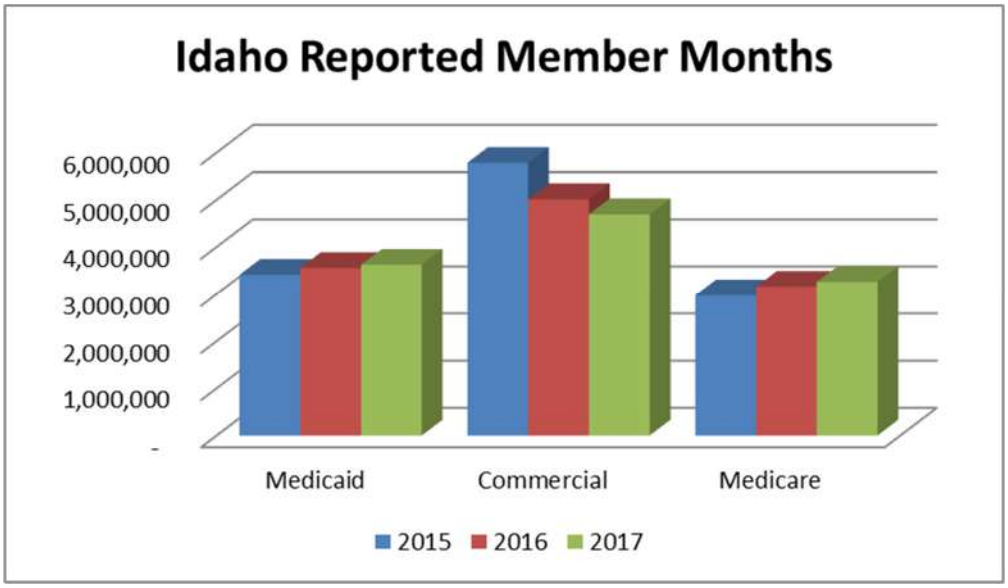
To collect the data for the analysis, commercial, Medicare and Medicaid (payers) were surveyed using the category of services classifications and definitions included in Appendix A. To isolate the effect on cost per member, member shifts between payers and membership growth was removed from the assumption, leaving member months as a constant in the original model.

5
2017 FINANCIAL ANALYSIS OBSERVATIONS

MEMBERSHIP SHIFTS

In the projected model, membership was held constant by the payer type. Enrollment trends show a decline in reported commercial membership and steady growth in the public sectors. Member months, as reported by the payers, counts each month of the year for each member reported as one. As shown in Figure 1, the increase in both Medicaid and Medicare member months was more than offset by the reduction in commercial payers reported member months.

FIGURE 1: CHANGES IN REPORTED MEMBER MONTHS



Shifts in membership can affect trend and PMPM costs by payer if there is a change in the overall acuity of the membership base. For instance, Medicaid experienced a large influx of membership in 2016 because of the introduction of Idaho's marketplace, which identified several beneficiaries as eligible for Medicaid. These beneficiaries were likely healthier as a whole than the base population used in original forecast. Conversely, the commercial payers reported significant decreases in family membership from 2015 to 2016 and showed a decrease in per member costs, indicating movement of high acuity beneficiaries to another payer.

CHANGES IN TREND

Restated costs for Medicaid recipients in 2015 and 2016 led to a restated Idaho trend of 0.8%, down from the previously reported 2.9% in the 2016 financial analysis. Reported trends in total for Idaho increased by 3.4% in 2017. The overall reported PMPM cost of care increased from $476.58 in 2016 to $492.96 in 2017.

TABLE 3: REPORTED TRENDS

PARTICIPANTS	BASELINE PMPM	2016 ACTUAL PMPM	2016 ACTUAL TREND	2017 ACTUAL PMPM	2017 ACTUAL TREND	2015–2017 TOTAL ACTUAL TREND	2015–2017 PROJECTED TREND
MEDICAID							
Children	$262.18	$265.87	1.41%	$271.51	2.12%	3.56%	11.33%
Dual Eligible	$1,392.94	$1,405.23	0.88%	$1,437.51	2.30%	3.20%	4.42%
Aged/Disabled (non-dual)	$2,145.39	$2,207.54	2.90%	$2,265.95	2.65%	5.62%	8.54%
Other Adult	$422.70	$410.47	-2.89%	$407.09	-0.82%	-3.69%	9.53%
COMMERCIAL							
Individual	$403.38	$530.14	31.42%	$558.63	5.37%	38.49%	10.29%
Family	$375.52	$347.91	-7.35%	$381.42	9.63%	1.57%	10.40%
MEDICARE							
Dual Eligible	$756.49	$876.43	15.85%	$790.41	-9.81%	4.48%	9.71%
FFS	$412.54	$425.64	3.18%	$432.23	1.55%	4.77%	9.98%
Medicare Advantage	$756.23	$849.44	12.33%	$818.63	-3.63%	8.25%	11.02%

ANALYSIS BY PAYER TYPE

Medicaid

Medicaid showed decreases in PMPM costs for adult non-dual, non-aged or disabled beneficiaries, dropping from PMPM costs of $422.70 in 2015 down to $407.09 in 2017. Medicaid showed an increase in overall PMPM costs from $495.92 in 2016 to $508.52 in 2017—an increase of 3.32%. Categories of service identified in the PCMH model were Inpatient, Emergency Room, Outpatient, Professional Specialty Care, Physical and Occupational Therapies (PT/OT) and Pharmacy. While those cost categories held to a 2.1% trend in 2016, the cost of Inpatient and Outpatient services drove the trend up 4.1% in 2017; and professional primary care costs increased by 4.6% in 2017. Overall, Medicaid cost avoided for 2016 and 2017, as shown in Table 4 is $66,335,153.

Commercial

While public payers showed decreases in PMPM trend, commercial payers reported a 9.2% increase in PMPM costs, driven by significant increases in costs for Outpatient services, Durable Medical Equipment (DME), and nearly doubling the cost of PT/OT. Like Medicaid, PCMH model assumption categories showed an increase of 17.6% in 2017 compared to 1.7% in 2016.

Professional primary care costs decreased by 13.5% in 2017. Commercial payers in the State exceeded payments nationally in 2016 and 2017 by $30,089,913.

Medicare

Increases driven by only the rise in PT/OT, Medicare reported significant improvement with negative trends in inpatient, emergency room, DME and prescription drug PMPM costs. Medicare reported PCMH model assumption categories with a 2.6% PMPM decrease in 2017 compared to an increase of 12.7% in 2016. Professional primary care costs decreased by 6.3% in 2017. While exceeding costs nationally in 2016, Idaho Medicare PMPMs went down in 2017 to show two-year costs avoided of $57,276,736.

TABLE 4: COST AVOIDED BY PAYER

PAYER	BASELINE PMPM	ACTUAL PMPM	ACTUAL TREND	OACT TREND	PROJECTED PMPM	COST AVOIDED PMPM	TOTAL COST AVOIDED
MEDICAID							
2015/2016	$492.18	$495.82	0.76%	3.95%	$511.61	$15.69	$59,193,893
2016/2017	$495.92	$508.52	2.54%	2.92%	$510.38	$1.86	$7,141,261
COMMERCIAL							
2015/2016	$381.41	$393.79	3.25%	5.11%	$400.89	$7.10	$35,582,245
2016/2017	$393.79	$429.96	9.19%	5.63%	$415.95	$(14.00)	$(65,672,158)
MEDICARE							
2015/2016	$533.39	$585.07	9.69%	3.59%	$552.53	$(32.53)	$(102,517,554)
2016/2017	$585.07	$565.35	-3.37%	5.02%	$614.41	$49.06	$159,794,291
Total							**$93,521,977**

6
CONCLUSION

As described in the AY2 Financial Analysis Report, Idaho's SHIP model testing is occurring within a dynamic health system environment; therefore, the results of this analysis cannot be directly attributed to the impact of the SHIP PCMH model on utilization and costs. These metrics are also impacted by other payer models being implemented in the State, changes occurring in membership enrollment and changes in members' utilization of services.

Cost avoided by Medicaid and Medicare exceeded the additional costs incurred by commercial payers by more than $93 million dollars. The cost avoidance assumptions for Medicaid show overall rate improvements, but not necessarily in PCMH categories. Commercial payers reported significant increases in total cost PMPMs in both individual and family/group categories. The increases in outpatient and PT/OT more than offset the costs avoided in inpatient costs. Medicare showed reductions in costs in nearly all categories except PT/OT.

In summary, these combined changes in the State may be bending the cost curve for public payers. Actual costs are $93.5 million less than projected for the first two years of the demonstration for all payers, and nearly $124 million for public payers. If the State can maintain the current cost avoidance trends, Idahoans should exceed the $89 million of projected cost avoidance in the SHIP Model Test Grant application.

APPENDIX A

DATA REQUEST

Data Request Template Sent to Payers on February 9, 2018:

Dear Multi-payer workgroup participants,

CMMI requires reports to monitor financial progress for the SIM grant Idaho received. Now that 2017 is complete, we are sending out the data request again. The attached spreadsheet is updated for 2017 but follows the exact same format reported in 2015 and 2016. Please review the spreadsheet and let me know if you have any concerns providing the requested data. Costs should be aggregated based on the category of service logic provided, but split by the category of aid or contract type listed in row 4 of the Report Template tab.

Your signed standard Mercer Client Confidentiality Agreement are still in effect. Reporting to CMMI will be done in aggregate such that no individual payer data will be discernable.

Please review both documents and let me know if you have any concerns about either document by February 15th. If not, we'd like to start receiving data on April 4th. If you're unable to meet that date, please let me know when you think you can get the template completed. I appreciate your participation in the SHIP and would like to make the reporting process as simple as possible.

Thank you!

Scott Banken, CPA

APPENDIX B

DATA R3QUEST TABLE

CY 2017

	MEDICAID/CHIP				PRIVATE/OTHER		MEDICARE		
	ADULT	CHILD	DUAL ELIGIBLES (ONLY)	DISABLED/ELDERLY (WITHOUT DUALS)	INDIVIDUAL	FAMILY	DUAL ELIGIBLE	FFS/NON-DUALS (PARTS A AND B)	MEDICARE ADVANTAGE PART C
Member Months									
Inpatient Hospital	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Emergency Department	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Urgent Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Outpatient Hospital	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Professional Primary Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Professional Specialty Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

	MEDICAID/CHIP				PRIVATE/OTHER		MEDICARE		
	ADULT	CHILD	DUAL ELIGIBLES (ONLY)	DISABLED/ELDERLY (WITHOUT DUALS)	INDIVIDUAL	FAMILY	DUAL ELIGIBLE	FFS/NON-DUALS (PARTS A AND B)	MEDICARE ADVANTAGE PART C
Diagnostic Imaging/X-Ray	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Laboratory Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
DME	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Dialysis Procedures	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Professional Other (e.g., PT, OT)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Skilled Nursing Facility	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Home Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Custodial Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
ICF/MR	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
HCBS	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Behavioral Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

	MEDICAID/CHIP				PRIVATE/OTHER		MEDICARE		
	ADULT	CHILD	DUAL ELIGIBLES (ONLY)	DISABLED/ELDERLY (WITHOUT DUALS)	INDIVIDUAL	FAMILY	DUAL ELIGIBLE	FFS/NON-DUALS (PARTS A AND B)	MEDICARE ADVANTAGE PART C
Prescription Drugs (Outpatient)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TOTAL	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**

APPENDIX C

CATEGORY OF SERVICE CLASSIFICATIONS

Use the following logic in order to classify claims and expenses.

EMERGENCY DEPARTMENT	
	837I or UB04: Revenue codes 0450, 0451, 0452, 0459, 0981
	837P or CMS1500: Procedure codes 99281-99285, G0380-G0384, G0390
URGENT CARE	
	837I or UB04: Revenue code 0456
	837P or CMS1500: Procedure codes S9083, S9088 and/or Place of Service code = 20
Dialysis	
	837I or UB04: Revenue codes 082x–088x
	837P or CMS1500: Place of Service = 65 or Rendering Provider Type = ESRD Treatment or Dialysis Facility
INPATIENT HOSPITAL	
	837I or UB04
	Bill Type: 011x or 012x
	BH is to be split out into the BH bucket by revenue codes: 0114, 0116, 0124, 0126, 0134,0136, 0144, 0146, 0154, 0156, 0204,
OUTPATIENT HOSPITAL (EXCLUDES ER)	
	837I or UB04
	Bill Type: 013x or 083x
SNF	
	837I or UB04: Bill Type 02xx
PROFESSIONAL PRIMARY CARE	
	837P or CMS1500: Rendering Provider Type: Family Practice, General Practice, Internal Medicine, Pediatrics, Preventive Medicine, Geriatrics

	http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2161CP.pdf
PROFESSIONAL SPECIALTY CARE	
	837P or CMS1500: Rendering Provider Type: Allergy & Immunology, Anesthesia, Dermatology, Emergency Medicine, Surgery, OBGYN, Ophthalmology, Orthopedics, Otolaryngology, Pathology
	http://cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/taxonomy.pdf Specialists are Allopathic and/or Osteopathic physicians with specialties in the attached list OTHER than the primary care specialties. Only CMS Specialty Codes 01–99 are to be included.
PROFESSIONAL OTHER	
	837P or CMS1500: Rendering Provider Type: All other specialties that do not fall into Primary Care or Specialty Care.
DIAGNOSTIC IMAGING/X-RAY	
	837P or CMS1500: Procedure Codes 70000–79999
LAB SERVICES	
	837P or CMS1500: Procedure Codes 80000–89999
DME	
	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html
	DME15-C is the more current file, but probably would not match data as well. File will need to be filtered to Idaho only data.
HH	
	837I or UB04: Bill Type 03xx or Revenue codes 0550, 0551, 0559, 057x, 0989
	837P or CMS1500 Procedure Codes:T0221, S5180, S5181, S9122-S9125, T1019-T1022, G0160-G0161,
	POS = 05 or Provider Type = Home Health Agency
CUSTODIAL CARE	
	837P or CMS1500: POS = 13, 14, 32, or 33
	or Procedure Code: 99324–99339
ICF/MR	
	837I or UB04: Bill Type 065x or 066x and
	Diagnosis codes 317.x-319.x for MR

BH	
	837P or CMS1500: Primary diagnosis codes 290–319 (excluding ICF claims)
	837I or UB04: Inpatient BH revenue codes: 0114, 0116, 0124, 0126, 0134,0136, 0144, 0146, 0154, 0156, 0204
HCBS	**HCBS SERVICES FROM WAIVER APPLICATION**
	Residential Habilitation
	Respite
	Supported Employment
	Community Support Services
	Financial Management Services
	Support Broker Services
	Adult Day Health
	Behavior Consultation/Crisis Management
	Chore Services
	Environmental Accessibility Adaptations
	Home Delivered Meals
	Non-Medical Transportation
	Personal Emergency Response System
	Skilled Nursing
	Specialized Medical Equipment and Supplies
PRESCRIPTION DRUGS	
	NCPDP or presence of NDC code.
Other	
	All other claims that don't fall into the above COS.

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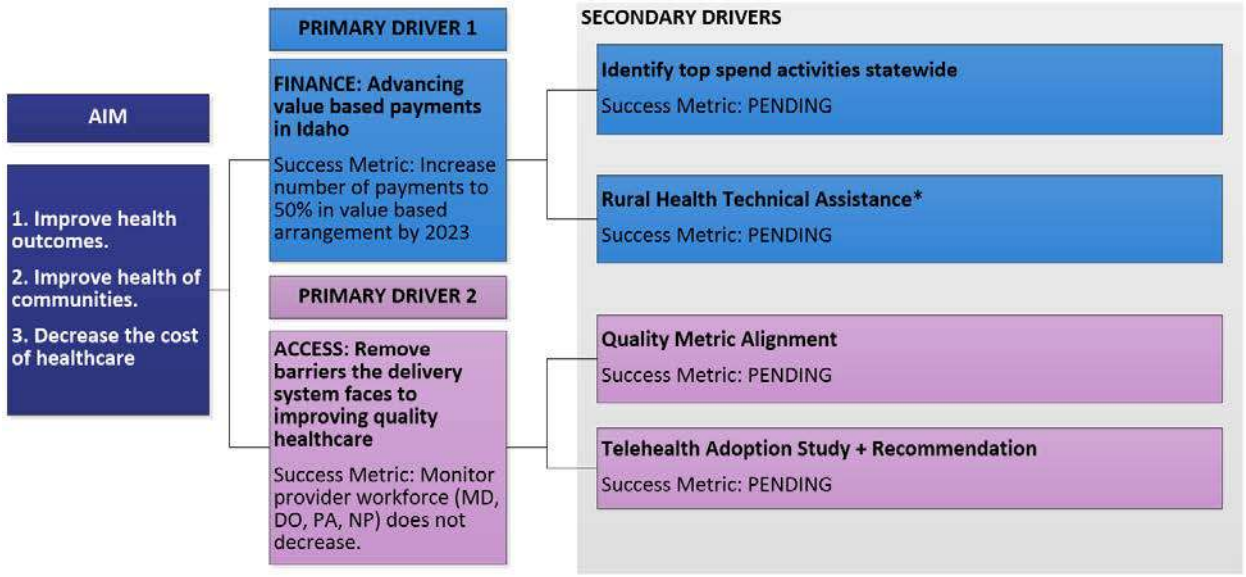
Payer Provider Workgroup Charter

Workgroup Summary:

Chair/Co-Chair	Norm Varin & Dr. Kelly McGrath
OHPI Staff Lead	Casey Moyer
PPW Charge (from HTCI)	Assist in developing, promoting, and advancing initiatives that increase value based while helping decrease cost and increasing quality.
HTCI Alignment	• Promote and support transformation by identifying opportunities for innovation that will help shape the future of healthcare. • Promote alignment of the delivery system and payment models to drive sustainable healthcare transformation. • Recommend and promote strategies to reduce overall health care costs.



Driver Alignment and Measurement:

HTCI Driver Alignment	Desired Outcome	Measurement	Workgroup Role
Finance	1. <These should be tied to the initiative> 2. 3.		

Planned Scope:

Deliverable 1:

Description:	Develop a operational plan and methodology to routinely collect and report the percentage of payments made in value based arrangements statewide.
Timeframe:	
Milestones:	

Deliverable 2:

Description:	Determine sub goals within each value based payment category to help inform initiative selection and gauge progress.
Timeframe:	
Milestones:	

Deliverable 3:

Description:	Determine the top spends (by carrier) in which collaboration at the payer provider workgroup level could increase the value based payment arrangement while decreasing cost and increasing quality.
Timeframe:	
Milestones:	

Deliverable 4:

Description:	Behavioral Health Integration Project <language needed from Jen Y>
Timeframe:	
Milestones:	

Membership and Composition:

General Information	Membership composition will consist of representatives from the following stakeholder groups:
	• Medicaid
	• Medicare
	• Commercial Carriers
	  o Blue Cross of Idaho
	  o Regence
	  o Select Health
	  o Mountain Coop
	  o Pacific Source
	  o Aetna
	  o United Health
	  o Humana
	• Self-Funded Employer
	• 1 representative from each of the following organizations:
	  o Idaho Hospital Association

	○ Idaho Medical Association ○ Idaho Primary Care Association ○ Idaho Academy of Family Physicians • Physicians • Independent Clinic Physician • <additional slots>
Member Selection	Co-Chair Invitation.
Terms	Membership shall be extended to individuals and organizations by the co-chairs as needed to address the initiative(s) of the workgroup. There are no set terms or limits for this workgroup.
Expectations of Members	• Members must participate in 75% of all meetings scheduled within the calendar year. • Members' designee may participate in up to 25% of the meetings scheduled within the calendar year. • Members are encouraged to send the same designee to the meetings instead of different individuals.

Change Management:

Changes to scope must be approved by HTCI.

Version Information:

Version	Author	Summary	Date
1.0	Moyer	Initial Drafting	08/02/2019

Final Acceptance:

Name/Signature	Title	Date	Approved via Email
			☐
			☐
			☐
			☐

Integrating, Leveraging, & Sustaining Team-Based Care

- To build upon the existing Idaho Integrated Behavioral Health Network into an enduring structure to demonstrate a hub and spoke model that serves as capacity-building platforms for the systematic integration of behavioral health and pharmacy into rural primary care clinics and practices.

- Ask: Support from HTCI to develop a demonstration project for multi-payer value based contracts for Team-Based Care. The demonstration project would leverage current and past integration projects initiatives.

Objectives Demonstration of Hub and Spoke Model Grassroots Learning Collaborative

- Develop a Hub and Spoke demonstration project for integrated behavioral health & Pharmacy workforce development and learning collaborative.
- Scale Up and replicate several Hub and Spokes throughout the state
- Analyze data to develop value based contracts for team-based care model

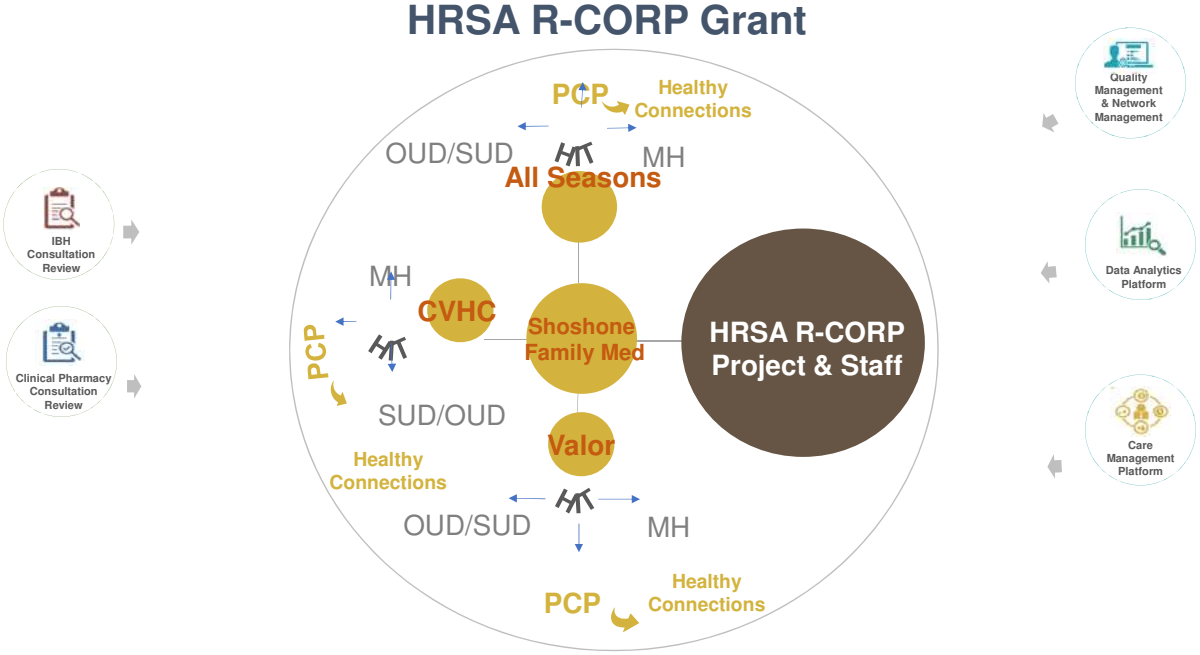
Create a workforce development program to train and support the integration of evidence-based pharmacy and behavioral health techniques and team-based care in rural primary care settings,

Train a cadre of local content experts to provide technical assistance for regional primary care providers on evidence-based and best practices for clinical and administrative integration of behavioral health & pharmacy services,

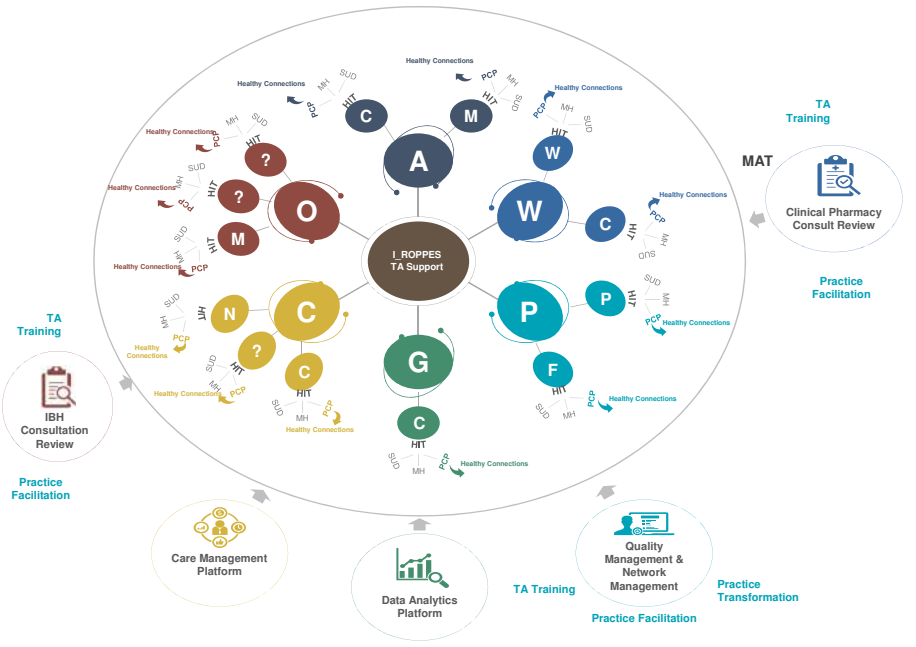
Develop and design a method to collect and analyze primary care clinic data capabilities to measure outcomes for behavioral health population to create a value based payment model for team based care.

Design and implement a robust Learning Collaborative for each of the hub and spokes to create a grassroots technical assistance program.

Design of Hub and Spoke Model
HRSA R-CORP Grant



Future State of Demonstration Project



Definitions

- HIT = Health Improvement Team
- HIP = Health Improvement Provider
- PCP = Primary Care Care
- SUD = Substance Use Disorder
- OUD = Opioid Use Disorder
- MH = Mental Health

Current and Past Integration Projects

- ROCOC – Family Health Services
- RIBHHN – SWDH & Valley Family
- I-ROPPES – Cornerstone Whole Healthcare Organization
- Cascade Family Medical Center
- Valor Health
- All Seasons
- Clearwater Valley & St. Mary's Hospital & Clinics
- Shoshone Family Medical Center
- Valley Family Health Care
- Saltzer Medical Group
- St. Luke's Fruitland
- St. Luke's Humphrey's Diabetes Center
- ROCCC – St. McCall

Overview Idaho Integrated Behavioral Health Network (IIBHN)

- Common vision to develop a behavioral health integration learning collaborative and to create a community of sharing and giving,
- Grassroots Volunteer Network of organizations, institutions, & individuals,
- Interested in advancing Implementation of BHI as part of Practice and Systems Transformation,
- Facilitate Training & Network Opportunities for workforce development,
- Guided by a Leadership Team – consisting of one individual from each group or organization.

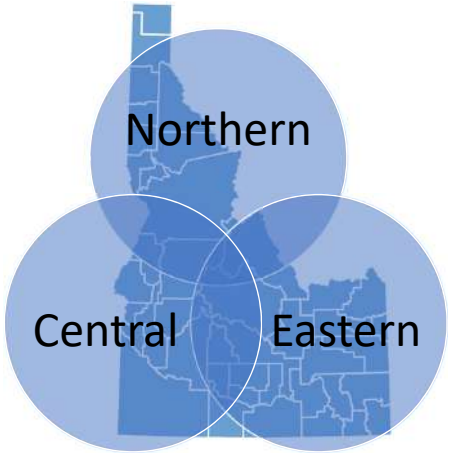
Overview Idaho Integrated Behavioral Health Network (IIBHN) Public Health District Hubs

Public Health District Hubs ("PHD Hubs")

- Regional Learning Collaboratives provide a neutral space to pursue the group's vision across the state.

PHD Hub Roles and Responsibilities as Conveners:

- Planning meetings
- Facilitating meetings
- Providing administrative support



Overview Idaho Integrated Behavioral Health Network (IIBHN) Regional & Statewide Trainings

Goal of creating state, regional, and local content experts to be mentors and educators across the state

Regional Trainings and Technical Assistance

- Clinical and Operational Trainings

Annual Statewide Conference (National & Local Presenters) 2019 IIBHN Conference

- Statewide Networking
- Research Trends
- Clinical Interventions
- Operational Implementations
- New team-based care partners and team members